Headaches

In an attempt to be able to better communicate what was going on, I systematically researched every type of headache I could find, collated the information into a word document, and made notes of how the headache was like some headaches. Since the aneurysm change, dietary changes, and what I think may be herx responses to certain changes/herbs and a round of anti-biotics that does kill the lyme spirochete - things have shifted.

Here are the notes

Headache Notes for Kurt

I've done some research about headaches and have come to the conclusion that no ONE type of headache is a good match for what is going on. My guess is that the headache is related to multiple things. I downloaded information from what seemed to be reliable resources and made notes about the headache.

It does not respond much to pain meds, so it seems, but oddly enough - the edge seems to be taken off with cinnamon, and in the past (haven't wanted to use it because of stomach issues) cayenne pepper.

The closets matches are:

Migraine (but no family history of migraines), atypical Cluster Headache (Cluster Headaches more common in men, atypical more common in female), & because of the pain with bending over - sinuses - my guess the sphenoid sinus - problems here can spread to the brain, brain tumor (low probability but include it just because I was told a brother has brain tumors and tumors in his spine, I think benign) and the red flags are.

These red flags may include: a change in previous headache pattern; headache unresponsive to therapy; any new motor (weakness), sensory, or visual symptoms or signs; a change in memory, personality **YES,** or thinking **SOMEWHAT**; prolonged/repetitious vomiting; or a headache getting worse when bending over **YES** coughing, sneezing, or Valsalva maneuver (straining, grunting) **SOMETIMES** These symptoms can frequently occur in benign headaches as well.

Signs and symptoms:

Cluster Headaches

Cluster Headaches

- Deep stabbing pain around the temple or the eye which is usually unilateral.
- Stuffy or runny nose
- Tearing or redness in eyes, droopy eyelids – **EYELID EDEMA frequently**

Migraine

- Moderate to severe, throbbing head pain.
- Most commonly one sided pain; less frequently both sides of the head are affected
- Pain located near the eye on affected side
- **Pain that worsens with physical activity – SOMETIMES, if have a bad headache, physical exercise (cardio) makes it worse, and bending over REALLY makes it worse!**
  - Sensitivity to light and/or sound
  - Nausea or vomiting
  - Debilitating pain that hinders daily activities - **SOMETIMES**

Pain and Other symptoms

- Pain during cluster headaches is far worse, significantly more severe than a migraine.
- Cluster headaches are frequently associated with Horner's syndrome, ptosis (drooping eyelids), conjunctival injection (which results in red, watery eyes), lacrimation (tearing), miosis (constricted pupil), eyelid edema, nasal congestion, rhinorrhea (runny nose), and sweating on the affected side of the face. The neck is often stiff or tender in association with cluster headaches afterwards, and jaw and teeth pain are sometimes reported.
- Sensitivity to light is more typical of a migraine, as is vomiting, but both can be present in some sufferers of cluster headache, although rare.
- It has been known to strike at the same time each night or morning, often at precisely the same time during the day a week later.

Prevalence

While migraines are diagnosed more often in women, cluster headaches are diagnosed more often in men. The male-to-female ratio in cluster headache ranges from 4:1 to 7:1. It primarily occurs between the ages of 20 to 50 years. Tension headaches are more common in both sexes, accounting for the vast majority of headaches.

Genetics

First-degree relatives of sufferers are more likely to have the condition than the population at large. **I DON'T RECALL ANY FAMILY MEMBERS SUFFERING FROM MIGRAINES OR HEADACHES**

Triggers

Cluster Headaches

- Nitroglycerin (glyceryl trinitrate)
- Alcohol
- Hydrocarbons (petroleum solvents, perfume)
- Heat and napping may also act as a trigger.
- Significant change in sleep or work schedules, with resulting decrease in sleep and REM

- **MY SLEEP ISN'T DEEP, I CAN SENSE THAT. WHEN ON THE MUSCLE RELAXANT/PAIN BLOCKER, FEEL DEEP SLEEP, WHEN NOT USING IT, SLEEP IS MUCH LIGHTER**

Migraine

According to the National Library of Medicine's Medical Encyclopedia, Migraine attacks may be triggered by:

- Allergic reactions
- Bright lights, loud noises, and certain odors or perfumes
- Changes in sleep patterns **– KEEPING A CONSISTENT PATTERN NOW, BUT HAD HABIT OF STAYING UP LATER ON WEEKENDS**
- Smoking or exposure to smoke
- Skipping meals -
- Alcohol –
- Menstrual cycle fluctuations, birth control
- Foods containing tyramine (red wine, aged cheese, smoked fish, chicken livers, figs, and some beans), monosodium glutamate (MSG), or nitrates (like bacon, hot dogs, and salami)
- Other foods such as chocolate, nuts, peanut butter, avocado, banana, citrus, onions, dairy products, and fermented or pickled foods

Compare Anything ››

vs.

Migraine vs. Tension Headache

Diffen › Health › Diseases

A **migraine** is a form of vascular headache. Migraine headache is caused by a combination of vasodilatation (enlargement of blood vessels) and the release of chemicals from nerve fibers that coil around the blood vessels. During a migraine attack, the temporal artery enlarges. (The temporal artery is an artery that lies on the outside of the skull just under the skin of the temple.) Enlargement of the temporal artery stretches the nerves that coil around the artery and cause the nerves to release chemicals. The chemicals cause inflammation, pain, and further enlargement of the artery. The increasing enlargement of the artery magnifies the pain.

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Tension headaches account for nearly 90% of all headaches and are probably experienced by most people at some time during their lifetime. These headaches are frequently associated with fatigue and stress, and generally respond to simple measures such as rest or over-the-counter pain medicines. The pain from a tension headache usually occurs on both sides of head and consists of a dull, steady ache.

Comparison chart

SINUS HEADACHES

http://www.mhni.com/headache-pain-faq/content-disclaimer/sinus-headache

Sinus headache typically occurs in the area of the sinuses (see Figure 1)—in the area of the cheeks (maxillary sinus), **NO** bridge of the nose (ethmoid sinus), or above the eyes (frontal sinus). **NO** Less often it may refer pain to the top or back of the head (sphenoid sinus—see Figure 2). **YES** Sinus headache may occur on one side or both sides of the head **YES** and the neck is typically not involved – DO HAVE **NECK TIGHTNESS SOMETIMES**. The symptoms are frequently worsened by bending over or coughing (as with migraine), **WHEN HEADACHE IS BAD WORSE WHEN BENDING OVER** and examination of the facial area may reveal local tenderness, redness, swelling, and possibly the presence of clear or discolored nasal discharge. **NOT MUCH DISCHARGE** Sinus disease can happen to people who suffer from migraine or to those who do not and may lead to increased migraine activity in migraine sufferers, often confusing the diagnosis.

http://www.mhni.com/headache-pain-faq/new-daily-persistant-headache

New Daily Persistant Headache

MHNI Headache Division discusses the diagnosis & treatment of New Daily Persistent Headache.

What is New Daily Persistent Headache?

New daily persistent headache (NDPH) is one of the important headache entities under the category of chronic daily headache. This is the group of primary headache disorders that also includes chronic migraine, chronic tension-type headache, and hemicrania continua. Only recently has NDPH been recognized as a distinct entity by headache specialists.

What key symptoms distinguish New Daily Persistent Headache?

New daily persistent headache is unique in that the headache is daily from onset, typically in a patient with no prior history. It can continue for years without any sign of alleviation despite aggressive treatment. The headache will start one day and in many instances continue as daily and unremitting pain. **YES – but had this LAST SEASON TOO**

There may be two subtypes of NDPH, a self-limited form which typically goes away within several months without any treatment, and a refractory form, which is difficult to treat.

A characteristic and unique feature of NDPH is that most patients are able to pinpoint the exact date when their headaches started.

Headache onset may occur in relationship to an infection or flu-like illness (such as mononucleosis), surgery (such as hysterectomy), or a stressful life event. NDPH is 2½ times more likely to occur in women than men. Average pain intensity is moderate in most people, though some individuals experience severe pain all of the time.

In order to meet the diagnostic criteria for NDPH, daily pain must be present for more than two months with untreated headache duration greater than four hours a day. Headache location is typically on both sides of the head and anywhere around the head. Pain is usually throbbing or pressing in quality, with associated symptoms such as nausea, light sensitivity, sound sensitivity, or lightheadedness. **YES**

In order to diagnose New Daily Persistent Headache, what other disorders must commonly be ruled out?

The diagnosis of NDPH must occur after many other conditions that can produce daily persistent headache are ruled out by a series of tests and other measures. Also the International Headache Society criteria must be met. Most importantly, the physician must consider disorders that can mimic NDPH.

What treatment is available for New Daily Persistent Headache?

Primary NDPH is considered one of the more difficult headaches to treat, though many patients do respond to appropriate treatment. Because some cases have features of migraine, patients may respond to migraine-type medication. Other patients respond to topiramate or gabapentin, which also can help some migraine patients. Pregabalin and many other drugs used for a variety of headache conditions are used by MHNI physicians to help patients with NDPH. Nonetheless, of all the headache conditions, it is one of the more stubborn headaches and more challenging to treat. Some patients require hospitalization to break the headache cycle.

MIGRAINE RELIEF – NO SUPPORT

http://www.mhni.com/headache-pain-faq/content-disclaimer/pain-disorders/fibromyalgia-chronic-fatigue-syndrome/trigeminal

Trigeminal Neuralgia

What is trigeminal neuralgia?

Scenario:

James is a 65-year-old man who awoke one day with severe pain in his face and jaw. The pain seemed to tear through his face like a lightning bolt. It was brief but excruciating pain which came in repeated flashes when activated. James could not shave over the right side of his face, chew tough foods or talk for any length of time without triggering pain. He could not even tolerate a light breeze blowing across his face.

James suffers from trigeminal neuralgia which is one of many different neuralgias. A neuralgia is a type of pain which is thought to be caused by nerve injury or irritation.

Trigeminal neuralgia, also known as *tic douloureux*, is a painful condition which affects the face. The trigeminal nerve provides all sensation, including pain, to the face, teeth, mouth, sinuses, meninges (coverings of the brain) and blood vessels of the head. There are two trigeminal nerves, one on each side of the head, and each has three branches supplying the upper, middle and lower parts of the face. The pain of trigeminal neuralgia is felt in the territory of one or more branches of this nerve. It usually occurs on one side of the

face; in rare cases it can affect both sides at the same time. Sinuses, eyes, mouth and teeth are also innervated by the trigeminal nerve.

JAW PAIN AND TEETH PAIN – MORE OF AN ACHY FEEL THAN SHARP

What does the pain feel like?

The pain is severe, brief, sharp, jolting and shock-like. A longer lasting deep, burning or dull pain may persist in between the lightening-like jolts. People with trigeminal neuralgia may have numerous attacks, up to several 100 each day. The duration of each painful jab is very brief, lasting only seconds. The pain may be triggered by chewing, talking, shaving, brushing teeth, light touch, cold air or wind blowing upon the face.

Who is the typical trigeminal neuralgia sufferer?

Trigeminal neuralgia usually occurs in people over 60 years old but may occur at any age. When trigeminal neuralgia occurs in a young person other diseases or conditions of the nerves can be possible causes. Trigeminal neuralgia can occur after an injury to the nerve such as from dental procedures including root canals, extractions, or decayed or cracked teeth. Some cases are the result of compression of the main nerve region by an artery as the nerve enters the brain stem. Some cases of trigeminal neuralgia have no identifiable cause.

Neuralgic pain is very intense and excruciating. People who have neuralgia are often depressed and frustrated. The pain affects every aspect of their lives because it occurs very frequently and rapidly without warning. People suffering with trigeminal neuralgia often find the pain to be so intense that they cannot even think clearly and may begin to believe that suicide is the only way to find relief.a

YES – WHEN THE PAIN IS BAD I DO QUESTION IF IT IS MY BODY SAYING IT HAS HAD ENOUGH.

What about treatments?

Fortunately, there are many different kinds of medical, anesthesiologic and surgical treatments available for the control of trigeminal neuralgia. Medications often used to control the pain of trigeminal neuralgia include carbamazepine, phenytoin, baclofen, divalproex sodium, gabapentin and clonazepam. Different kinds of anesthesiologic treatments are available including trigeminal nerve blocks, radiofrequency neurolysis (heating the nerve with a focused microwave), cryoneurolysis (freezing the nerve) and radiosurgery (radiation treatments). Surgery to expose the trigeminal nerve and remove blood vessels which may be pressing on the nerve is sometimes necessary.

Meniere's Disease

Dizziness is a common feeling, especially among headache sufferers. Some will experience true vertigo—the sensation that the room is spinning, or that they themselves are spinning. Although this very disturbing sensation can be caused by a number of illnesses, one possible diagnosis is ***Meniere's disease***.

ISSUES WITH BALANCE – 2 weeks of vertigo this fall. FELL FLAT ON MY FACE TWICE. VERTIGO CLEARED. BEEN DOING INNER EAR EXERCISES.

Hypnic Headaches

Hypnic headache, or headache during sleep, is a rare primary headache disorder occurring only in the senior population, with onset typically around the age of 60. Women are more likely to experience hypnic headache than men. To be called "hypnic headache," the headache must occur exclusively at night or during the day during napping. The attacks are very painful, often awakening the afflicted individual at the same time each night. The patient may be awakened during a dream by diffuse pain and nausea.

AWARE OF HEADACHES AT NIGHT – have been able to go back to sleep

http://www.mhni.com/headache-pain-faq/unique-neurological-conditions/chronic-paroxysmal-hemicrania

Chronic Paroxysmal Hemicrania

Chronic paroxysmal hemicrania (CPH) is a unique headache syndrome that falls into a category known as "indomethacin responsive headaches." It is very similar to cluster headache but is less common. In fact, some authors have labeled CPH as "atypical cluster headache."

CPH patients have multiple headaches per day (on average greater than 5), more than what is seen in cluster headache. Each attack is usually short-lived, with most lasting between 5 and 30 minutes. The pain is always one-sided, very severe, and seems to be concentrated around the eye, temple, and forehead region. There are associated symptoms of watering of the eye and eye redness; even drooping of the eyelid has been reported.

Unlike cluster headache, CPH is usually seen in females. Children are not immune to this condition-it has been reported to occur in girls as young as six years old. Although patients affected may wake up with an attack, this does not seem to occur as regularly as it might in persons with cluster headache. In addition, the nausea and vomiting which seem to be so prevalent for patients with migraine are not seen in CPH.

Individuals who experience CPH may have remissions of their attacks and pain, at times lasting many months. They may also not be able to identify specific triggers for onset of another attack.

While we have not yet identified the specific pathophysiology (underlying physical cause) behind CPH, it seems that the trigeminal nerve and hypothalamus is involved. Unfortunately, many treatments that are effective in treating other forms of pain caused by a similar mechanism do not seem to work when treating CPH. **FOUND HEADACHE RESISTANT TO PAIN MEDS** One medication that will always eliminate CPH is indomethacin; hence the term "indomethacin responsive headaches." For patients who are unable to use this medication, other treatment strategies are being evaluated. However, other headache medications, such as triptans, usually do not have an effect on CPH.

Although MHNI physicians are usually able to make a diagnosis of CPH based on a person's history and clinical symptoms, there are underlying lesions in the brain that can lead to similar symptoms and attacks (e.g., tumors, arteriovenous malformation). Because of this, various tests of the brain are recommended to exclude structural abnormalities.

Key clinical features

1. Pain is one-sided and usually localized to the eye, ear, temple, forehead, or lower jaw region. **Pain can be both sided, Pain in lower jaw, Pain in ear, no pain in forehead usually**
2. A range of pain forms (throbbing, boring, stabbing, etc.) is possible, with moderate to severe intensity. Persisting pain between

acute attacks is reported. **YES**

3. Attacks of pain last 2-25 minutes, averaging 10-15 minutes (range 2-120 minutes). (Cluster headache attacks have a mean duration of 45 minutes.) IN TERMS OF INTENSITY. **Always there, but has periods of greater intensity**
4. Patients generally prefer quiet and rest; some patients pace, as in cluster headache.
5. Attack frequency may be up to 40 per day but average 10-20 attacks per day.
6. In the episodic form, the headache phase is 2 days to 4.5 months. Remission is 1-30 months. **YES**
7. Nighttime awakening occurs. **YES**
8. Same side symptoms occur, similar to those in cluster headache:
    - **eye watering/nasal** congestion or discharge/eye congestion or redness;
    - forehead perspiration; NO
    - mild contraction of the pupils; NOT SURE
    - eyelid swelling; **YES**
    - light sensitivity; **YES**
    - nausea; **YES**
    - slow/fast heart rate; and
    - eyelid drooping. **NO**
9. Headache can be provoked by movement in 10% of cases; pressure on cervical region may precipitate an attack. **NOT AWARE**
10. Provocation by alcohol. **POSSIBLY**

Patients will frequently resort to excessive aspirin or over-the-counter (OTC) ibuprofen to control pain, perhaps due to the similarity in effect of indomethacin.

Some authorities, including Dr. Saper and the medical staff at MHNI, believe that the neck is sometimes involved as a cause, and neck treatments of various types can be helpful. Abnormalities around the pituitary gland can also mimic CPH, and this area must be examined by MRI scans.

NECK ISSUES – PITUARY GLAND DOES WHAT?

http://www.mhni.com/headache-pain-faq/content-disclaimer/headaches-brain-tumors

Is This A Brain Tumor That Hurts?

Alicia R. Prestegaard, M.D. answers frequently asked questions regarding the relationship between headaches and brain tumors.

Are headache and brain tumors related?

MOST LIKELY NOT – we did an MRI THAT DIDN'T SHOW ANYTHING – but do have a brother last I heard, dying, with tumors in brain and along spine.

Headache is a common symptom that may occur in otherwise healthy individuals. Typically, physicians are not concerned if the headache is occasional, mild, of short duration, and caused by identifiable factors (e.g., flu-like illness, sinus infection, fasting, sleep deprivation, or alcohol-induced "hangover"). However, patients who experience frequent or severe headache often worry about the possibility of a more serious underlying condition such as a life-threatening brain tumor.

Though very rare in the total population of patients with recurring headaches, approximately 50% of patients who do have brain tumors have a headache as a presenting complaint, and up to 60% of patients develop headaches as the disease progresses. Unfortunately, it is often impossible to diagnose a brain tumor based upon the description of the headache itself. Some patients do provide clues when presenting with seizures or persistent neurological symptoms.

What symptoms differentiate a brain tumor from other headaches?

Typical brain tumor headaches are "tension-like," aching in nature, and can occur intermittently with a gradual onset and resolution over a few hours. The headache can also be throbbing, resembling common migraine. There have been reports in the literature of patients whose brain tumors presented with classical migraine-like headache with aura which progressively worsened over a few months. Tumors can also obstruct cerebrospinal fluid flow which can cause headaches. **YES**

In a patient with a normal neurological exam and no other complaints, the sole symptom of headache is rarely related to a brain tumor. Certain specific features of headache have been identified as "red flags," which may suggest the presence of a structural abnormality (lesion), such as a brain tumor.

These red flags may include: a change in previous headache pattern; headache unresponsive to therapy; any new motor (weakness), sensory, or visual symptoms or signs; a change in memory, personality **YES,** or thinking **SOMEWHAT**; prolonged/repetitious vomiting; or a headache getting worse when bending over **YES** coughing, sneezing, or Valsalva maneuver (straining, grunting) **SOMETIMES** These symptoms can frequently occur in benign headaches as well.

Smokers or patients with a history of cancer, including lung, breast, prostate, or neck cancer, are at increased risk of metastatic spread of the tumor to the brain. Since pediatric tumors are typically located in the brainstem (lower portion) of the brain, they commonly induce specific symptoms, which physicians identify with careful history taking and examinations. Adults as well as children must undergo proper evaluation by an experienced physician, often a neurologist, and testing, usually with an MRI, is necessary.

How are brain tumors diagnosed?

Quite often it is not a headache that leads to the diagnosis of a brain tumor. Depending on the location of the tumor, it may take months or even years for the lesion to increase in size sufficiently to produce symptoms. Some tumors are discovered accidentally, such as during routine screening for migraines or following a minor head trauma, though this is very uncommon.

Frequently patients with brain tumors seek evaluation by a physician because of other symptoms. For example, they may suddenly or gradually develop visual disturbances, weakness on one side of their body, slurred speech, hearing loss, ringing in the ears, imbalance, dizziness, memory and/or cognitive problems, seizures, or even incontinence. An abnormal neurological examination is the most worrisome predictor of structural brain lesion.

What steps does the physician take when a brain tumor is diagnosed?

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It is the role of the physician to determine which patients require further testing for potential serious illness. Usually an MRI scan of the head with contrast enhancement is the most sensitive and preferable. In some cases additional studies should be ordered, such as a CT scan, or imaging of other parts of the body to determine if a primary tumor may be present. Some patients may require a lumbar puncture (spinal tap) to evaluate the spinal fluid, which can provide a clue to the cause of headaches.

If a tumor is present, the patient will be evaluated by both a neurosurgeon and often an oncologist. The neurologist is frequently involved in management of the patient with brain cancer in terms of monitoring the neurological status and treating complications, such as brain edema, epilepsy, strokes, pain, etc.

Summary

The good news is that for the 40 million patients with recurring headaches in the United States only a very small percentage have serious disease. The occurrence of brain tumors in the headache population is extremely low. At MHNI it is particularly rare, since by the time most patients reach the Institute, they have been evaluated by many physicians, and the most common headaches treated at MHNI are the primary headaches, such as migraine and related disorders. Nonetheless, periodic testing is necessary in many instances since even in patients with lifelong benign, primary headaches more serious conditions may superimpose without apparent symptom change. Since most of our patients have daily headache, the evolution of a secondary cause of headache must be considered even when symptoms are not necessarily altered initially.

CERVICOGENIC

see notes

Ruled out somataformic

http://ihs-classification.org/en/02_klassifikation/03_teil2/12.01.00_psychiatric.html

No health issues until mid-thirties: shingles first big pain, then PTSD

FULL ANSWER

A scalp that is sore to the touch can also indicate temporal arteritis, a condition in which the blood vessels that carry blood to the head become inflamed. The exact cause of temporal arteritis is not completely understood, however it is believed to be triggered by an abnormal immune response and has been associated with antibiotic use, according to Medline Plus. Additional symptoms include throbbing on one side of the head, pain in the jaw, fever and a general feeling of malaise.

Tenderness on the top of the head and scalp can also be caused by occipital neuralgia, a condition caused by inflammation of the nerves that travel from the spinal cord to the top of the head become inflamed or injured, according to WebMD. Additional symptoms of the condition include throbbing pain that first develops at the base of the head, severe, shocking pain on both sides of the head, light sensitivity and pain behind the eyes. Occipital neuralgia symptoms may be confused with those of a

migraine headache. Treatments for the condition depend on the underlying cause of nerve inflammation, but symptoms can be soothed with warm compresses and over-the-counter pain medications.

occipital neuralgia medication